NORTHWEST TERRITORIES CORONER'S SERVICE

2007 ANNUAL REPORT

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HISTORY OF CORONER'S SERVICE

The office of the Coroner is one of the oldest institutions known to English law. The role of the "coroner" in England has been noted in references dating back to the time of the Saxon King Alfred in 925 A.D. However, the historical development of the office can be traced back to a time near the Norman Conquest when the Coroner was to achieve an important role in the administration of justice.

It is generally accepted that the office was not regularly instituted until the end of the 12th century. One of the first detailed statutes concerning coroners was the Statute of Westminster of 1276. The title of the office has varied from "coronator" during the time of King John to "crowner," a term still used occasionally in Scotland.

One of the earliest functions of the Coroner was to enquire into sudden and unexpected deaths where in some cases a fee was to be paid to the crown. The Coroner was charged with the responsibility of establishing the facts surrounding a death, a duty that provides for the basis for all coroner systems in use today.

The *Coroners Act* established the territorial jurisdiction of the Coroner. The duties of the Coroner have been modified over the centuries; however the primary focus continues to be the investigation of sudden and unexpected deaths. With the growth of industrialization in the 19th century, social pressure demanded that the Coroner also serve a preventative function. This remains an important element of the Coroner's Service.

There are two death investigation systems in Canada: the Coroner system and the Medical Examiner system. The Coroner system has four main roles to fulfill: investigative, administrative, judicial and preventative. The Medical Examiner system involves medical and administrative elements. The Coroner and the Medical Examiner both collect medical and other evidence in order to determine the medical cause and manner of death. The Coroner receives the information from a variety of sources. The Coroner examines the investigative material, sorts out facts and comes to a judicial decision concerning the death of an individual. The Coroner can also make recommendations that may prevent a similar death.

In the Northwest Territories, the Coroner's Service provides a multi-disciplinary approach to the investigation of death by lay coroners appointed by the Minister of Justice. NWT coroners are assisted by the Royal Canadian Mounted Police and a variety of other experts when required.

INTRODUCTION

The Coroner's Service, organizations and administrative purposes, falls within the Department of Justice. The Office of the Chief Coroner is located Yellowknife and oversees all death investigations. Currently there are 39 coroners throughout the Northwest Territories. They provide service in the communities and regions in which they reside.

In the Northwest Territories, all sudden unexpected deaths must be reported to a coroner. The Coroners Service is responsible for the investigation of all reportable deaths in order to determine the identity of the deceased and the facts concerning when, where, how and by what means the deceased came to their death. The Coroner's Service is supported through efforts by the Royal Canadian Mounted Police, Fire Marshall's Office, Workers' Compensation Board, Transport Safety Board and various other agencies who work closely with the Coroner's Office.

The Chief Coroner Percy Kinney resigned as Chief Coroner effective October 1, 2007.

The Deputy Chief Coroner is Cathy Menard. Ms. Menard joined the Coroner's Service in February of 1996. She has been with the Department of Justice for 24 years.

There are no staffed facilities in the Northwest Territories to perform autopsies. When an autopsy is required, the body is transported to Edmonton for the procedure by the Chief Medical Examiners Office. Following the post mortem, the remains are sent to Foster & McGarvey Funeral Chapel, under contract for preparation and repatriation. Toxicology Services are provided to the Coroner's Service by Dynacare Kasper Medical Laboratories in Edmonton and on occasion by the Chief Medical Examiner's Office in Alberta.

MANNER OF DEATH

All Coroner Reports and Jury Verdicts determine the manner of each death. All deaths investigated by the Coroners Service are classified in one of five distinct categories: Natural, Accident, Suicide, Homicide or Undetermined.

NATURAL covers all deaths primarily resulting from a disease of the body and not resulting from injuries or abnormal environmental factors.

ACCIDENTAL covers all accidental deaths including motor vehicle incidents where there is no obvious intent to cause death. This classification includes any death resulting from an action or actions by a person which results in the unintentional death to him/herself or any death to any person that results from the intervention of a non-human agency.

SUICIDE refers to any death from a self inflicted injury where there is apparent intent to cause death.

HOMICIDE includes any death resulting from injuries caused directly or indirectly by the actions of another person (with the exception of unintentional motor vehicle accidents). Homicide is a neutral term that does not imply fault or blame.

UNDETERMINED is any death which cannot be classified in any of the other categories. The actual cause of death may or may not be known in these cases. An example of an undetermined death would be a drug overdose where it is unclear if the victim intended to die.

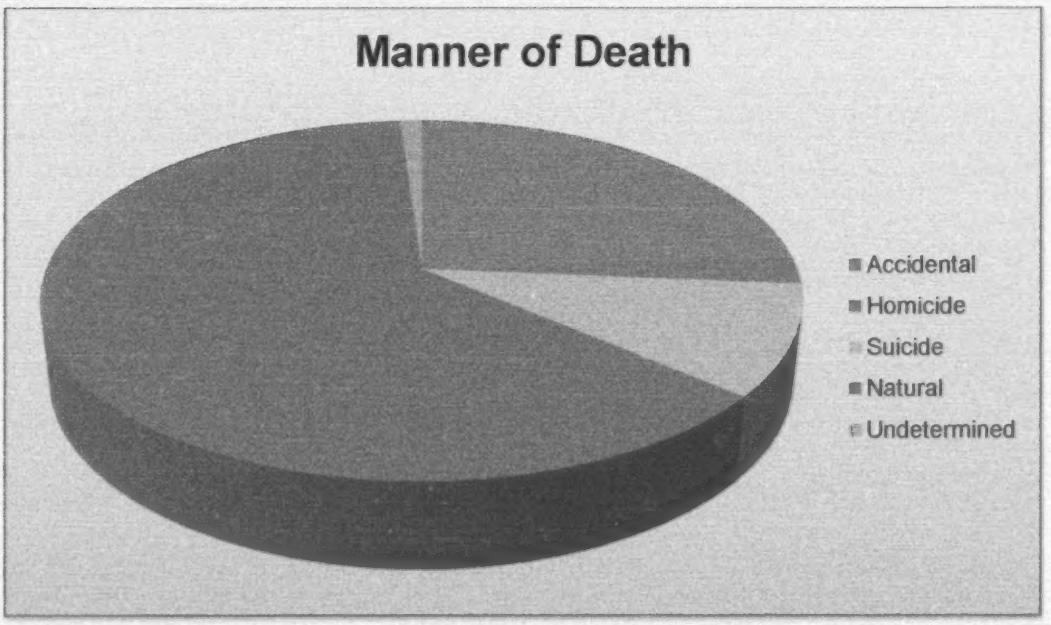
Coroners are instructed to make every effort to classify a death in one of the other existing categories before considering a classification of undetermined.

*(**UNCLASSIFIED** is reserved for any case work that ultimately does not result in another classification. It is primarily used for found remains which are analyzed and determined to be non-human.)*

CASE STATISTICS

TOTAL CASES

Manner of Death	Number	Percent (%)	Population %
Accidental	22	24.18	0.053
Homicide	2	2.20	0.005
Suicide	9	9.89	0.021
Natural (includes Non-Coroner cases)	57	62.64	0.136
Undetermined	1	1.10	0.002
Unclassified	0	0.00	0.000
Total	91	100.00	*0.217

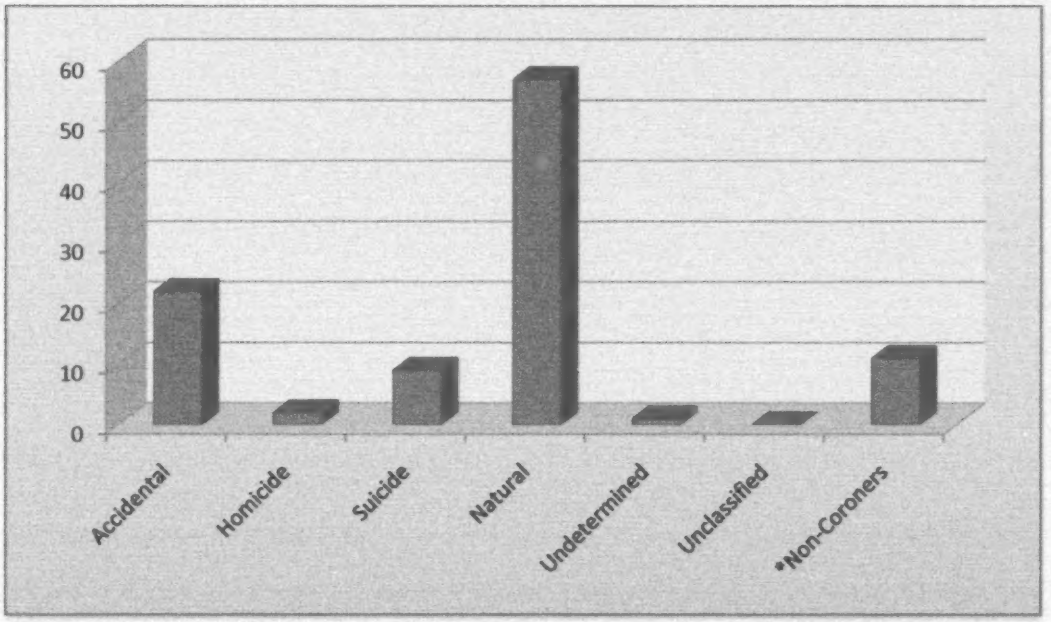


Non-Coroner cases are natural deaths that are reported to the Coroner's Service but do not fall under the reporting criteria required under the Coroner's Act. They must therefore be "Natural" in manner.

Unclassified cases are not represented in the population figures since they are non-human in nature. Also, in 2007 there were no cases determined as unclassified.

* Based on a population of 41, 861 in the NT re: stats.gov.nt.ca for 2006

CASELOAD BY MANNER OF DEATH



* The non-coroner's cases are also included in the natural case load of 56.

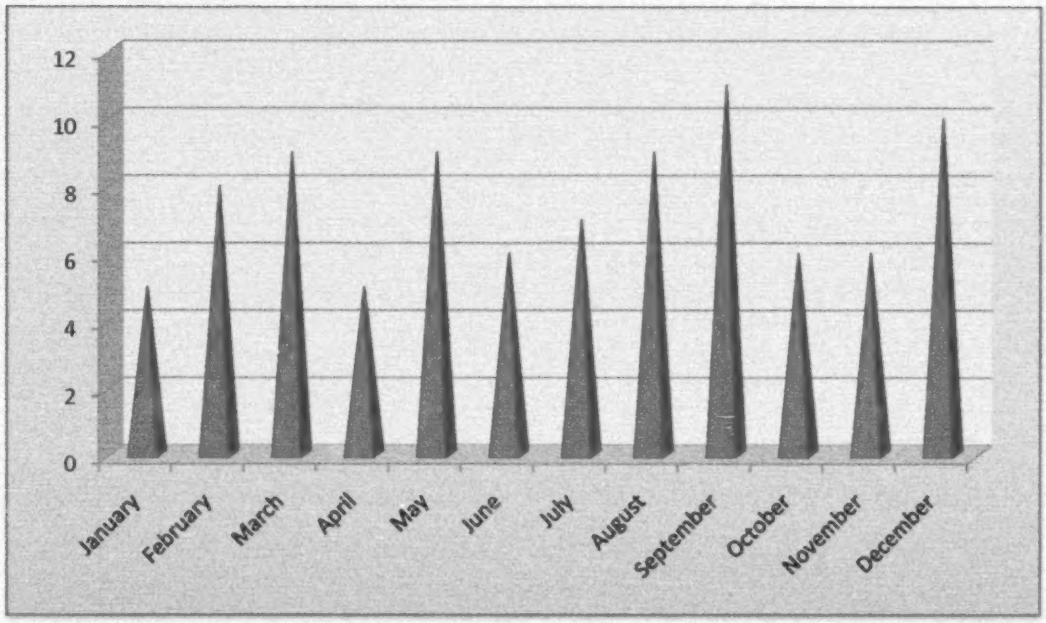
CASELOAD BY MANNER OF DEATH/COMMUNITY

Community	Accidental	Homicide	Suicide	Natural	Non-Coroners	Undetermined	Total
Aklavik	1			2			3
Behchoko	1			1	1		3
Colville Lake					1		1
Deline			1				1
Fort Good Hope	1			2	2		5
Fort Liard	1			1			2
Fort McPherson			1	1	1	1	4
Fort Resolution				3			3
Fort Simpson	1			3			4
Fort Smith	1	1	1	2			5
Gameti				1			1
Hay River	+3	1		7			11
Inuvik	1		2	2			5
Lutsel K'e			1				1
Paulatuk					1		1
Tuktoyaktuk	2		1	1			4
Tulita					1		1
Whati					1		1
Yellowknife	*10		2	20	3		35

*Three of these were the result of a single airplane crash.

+One of these occurred in Edmonton.

CASELOAD BY MONTH



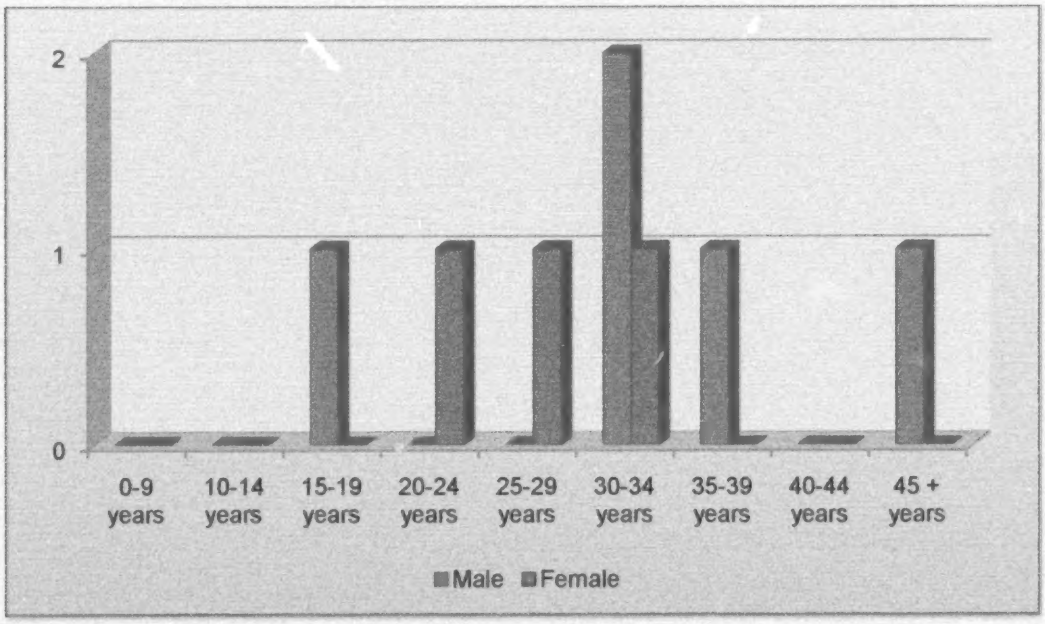
CASELOAD BY MANNER/MONTH

Month	Accidental	Homicide	Suicide	Natural	Non-Coroners	Undetermined	Total
January	3	0	0	1	1	0	5
February	1	0	1	5	1	0	8
March	1	0	2	4	2	0	9
April	2	0	0	3	0	0	5
May	1	0	1	6	1	0	9
June	0	1	0	4	1	0	6
July	3	0	1	3	0	0	7
August	2	0	1	3	3	0	9
September	3	0	2	3	2	1	11
October	2	1	0	3	0	0	6
November	1	0	1	4	0	0	6
December	3	0	0	7	0	0	10
Total	**22**	**2**	**9**	**46**	**11**	**1**	**91**

SUICIDE BY GENDER/AGE

Age Group	Male	Female	Total
0-9 years			
10-14 years			
15-19 years	1		1
20-24 years		1	1
25-29 years	2		2
30-34 years	2	1	3
35-39 years	1		1
40-44 years			
45 + years	1		1
Total	**7**	**2**	**9**

Of the nine suicide deaths in 2007, seven were male and two were female while three of the suicides occurred in persons 30-34 years of age.

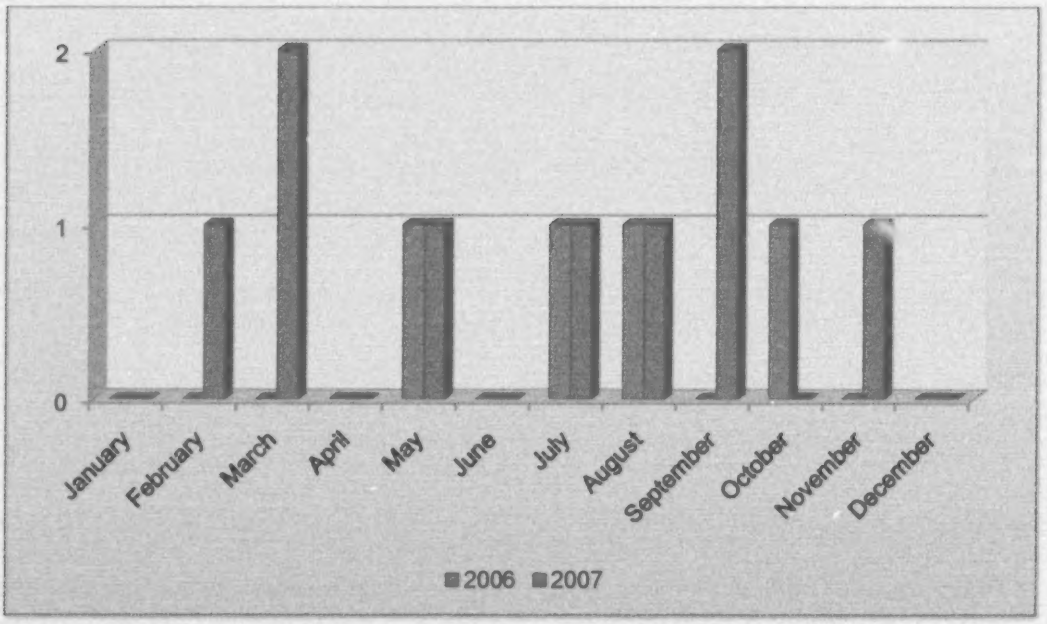


SUICIDES BY MONTH/COMMUNITY/GENDER/AGE/METHOD

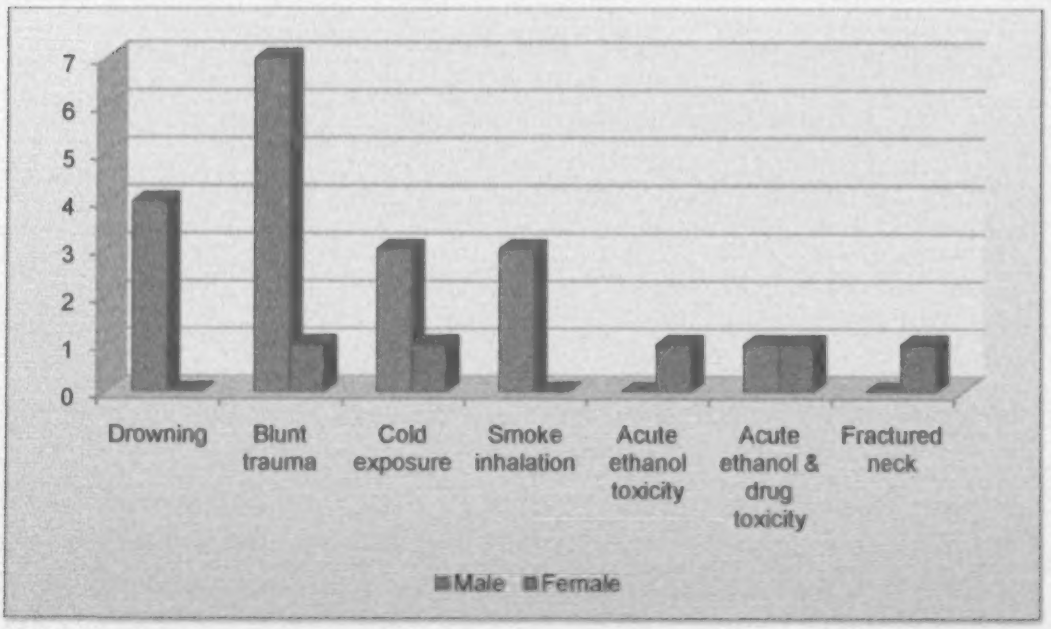
Month	Community	Gender	Age	Method	Alcohol Involvement
February	Lutsel K'e	Female	23	Hanging	Yes
March	Deline	Male	35	Gunshot	Yes
	Inuvik	Male	48	Hanging	Yes
May	Yellowknife	Male	26	Hanging	Yes
July	Tuktoyaktuk	Male	30	Gunshot	Yes
August	Fort McPherson	Female	30	Overdose	Yes
September	Inuvik	Male	30	Gunshot	No
	Yellowknife	Male	18	Hanging	Yes
November	Fort Smith	Male	25	Gunshot	Yes

Hanging and self-inflicted gunshot wounds each accounted for 4 of the 9 suicides in 2007.

SUICIDES BY MONTH 2006 – 2007 COMPARISON



ACCIDENTAL DEATH BY CAUSE/GENDER



Cause of Death	Male	Female	Total	Alcohol Related
Drowning	4	0	4	1
Blunt trauma	7	1	8	2
Cold exposure	3	1	4	4
Smoke inhalation	3	0	3	2
Acute ethanol toxicity	0	1	1	2
Acute ethanol & drug toxicity	1	0	1	1
Fractured neck	0	1	1	1
Total	**19**	**3**	**22**	**13**

Accidental death accounted for approximately 24% of all deaths reported to the Coroner's Service in 2007. The majority of deaths (19 of 22, or 86%) were males.

Drowning was the cause in 4 of the 22 accidental deaths (18%).

SUDDEN INFANT DEATH SYNDROME

Sudden Infant Death Syndrome (SIDS) is the most common cause of death in infants between 2 weeks and 6 months of age. The finding of a death by SIDS is done by exclusion of any other identifiable cause. The actual reason why these previously healthy infants die suddenly and unexpectedly is not currently known but research is ongoing.

There were no deaths by SIDS in 2007.

NATURAL & NON-CORONER CASES

Natural	Non-Coroner	Coroner
57	11	46

POST MORTEMS

Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
4	4	5	2	1	3	3	5	4	5	0	4

A post mortem is conducted when the cause and/or manner of death cannot otherwise be determined or when it appears appropriate to conduct the procedure. The autopsy may also be a means of determining the identity of the deceased.
A total of 40 autopsies were conducted in 2007.

CORONER APPOINMENTS

The Office of the Chief Coroner has the statutory authority to recommend the appointment and removal of coroners. It is desirable for each community to have local coroners; therefore recruitment of local coroners is done by the Coroner's Office, the Municipality or Band and the RCMP. Candidates must complete an application form outlining any special skills or training that they have which would assist them in the position of coroner. Applicants are also required to have written support from their Municipality or Band office and their local RCMP detachment. The letters of support and a recommendation of appointment by the Chief Coroner are then sent to the Minister of Justice for appointment. The applicant's MLA is also notified of the intended appointment. Coroners are appointed by the Minister of Justice for a three year period.

Currently there are 39 Coroners across the Northwest Territories; 17 are aboriginal. There are 25 male (10 aboriginal) coroners and 14 female (7 aboriginal) coroners.

The Coroners and the communities in which they reside are as follows:

Aklavik – Arnie Steinwand

Colville Lake - Wilbert Kochon

Deline - Elizabeth Takazo

Fort Good Hope - Ester Charney

Fort Liard - Alan Harris, John Chalk

Fort McPherson - Jamie Lee Carpenter, Winnie Greenland

Fort Providence - Robert Head

Fort Smith - Pat Burke, Sandy Napier, Murray Scott, Don Tourangeau

Fort Simpson - John Herring, Peter Shaw, Steve Catto

Hay River - Doug Swallow, Jim Forsey

Inuvik - Maureen Gowans, Gerry Kisoun, Brian Fraser MacDonald, Elizabeth Drescher

Lutselk'e – Alfred Lockhart

Norman Wells - Dudley Johnson, Valerie McGregor

Paulatuk – Bernadette Emma Nakimayak

Sachs Harbour - John Keogak

Tsiigehtchic – James Andrew Cardinal

Tulita - Edward McPherson Jr.

Tuktoyaktuk - Anita Pokiak, Barney Masazumi

Wha ti - Carolyn Coey-Simpson

Yellowknife - Bethan Williams, Garth Eggenberger, Jennifer Eggenberger, Wendy Eggenberger, Fred Whittlinger, Cathy Lee Menard & Percy Kinney (October 1, 2007)

CONCLUDING CORONERS' INVESTIGATIONS

REPORT OF CORONER

All coroner cases are generally concluded by either a Report of Coroner or by Inquest. The most common method used is the "Report of Coroner".

The Report of Coroner is a document outlining the results of a coroner's investigation. It provides clarification of facts and circumstances surrounding the death. The Report establishes the identity of the deceased, classifies the death, and includes any recommendations that may prevent a similar death. A Report of the Coroner and a Report of the Chief Coroner are completed in all death investigations with the exception of cases where an inquest has been called. At Inquest, the Jury Verdict takes the place of a Coroner's Report.

Recommendations are often made and are forwarded to the appropriate department, person or agency in hopes of providing valuable information that may prevent a similar death. Coroner Reports, containing recommendations, are distributed as required and responses are monitored. A synopsis of selected Coroner's Reports containing recommendations is attached. (See Appendix "A")

CORONER'S INQUESTS

Coroner cases that are not concluded by a Report of Coroner are ordinarily finalized by the use of a Coroner's Inquest which is a quasi-judicial hearing held in an open forum. The proceeding utilizes a 6 panel jury and hears testimony from sworn witnesses. The inquest is not a mechanism to resolve civil disputes nor is it used to conduct prosecutions. It is a fact finding proceeding which provides information and recommendations.

A coroner must hold an inquest when the deceased was involuntarily detained in custody at the time of the death. An inquest can also be held when, in the opinion of a coroner, it is necessary to:

a) identify the deceased or the circumstances of death;

b) inform the public of the circumstances of death where it will serve some public purpose;

c) bring dangerous practices or conditions to the knowledge of the public and facilitate the making of recommendations to avoid a preventable death; or

d) inform the public of dangerous practices or conditions in order to avoid future preventable deaths.

If a coroner determines that an inquest is not necessary, the next of kin or other interested person may request that an inquest be held. The Coroner shall consider the request and issue a written decision. This may be appealed to the Chief Coroner, who shall consider the merits of the appeal and within 10 days of receipt of the appeal, provide a written decision with reasons. Subject to the power of the Minister of Justice, under section 24 of the *Coroners Act*, the decision of the Chief Coroner is final.

There was one Inquest held in the Northwest Territories during this reporting period. (See Appendix "B")

APPENDIX "A"

SUMMARY OF SELECTED CORONERS' REPORTS CONTAINING RECOMMENDATIONS (CONCLUDED IN 2007)

CASE # 1

A 34 year old woman was found dead in a male parolee's living room by the RCMP. The police were acting on a complaint that she had not returned from a scheduled visit with the parolee living at that address.

The deceased was found naked on the living room floor of the apartment. It was apparent that she had sustained significant traumatic injuries to the head. A hammer was located on the floor near the body of the deceased.

RCMP secured the scene and began a criminal investigation into the death and conducted a search for the male occupant of the apartment. A government vehicle in the care of the deceased was missing and it was presumed that the parolee had taken the vehicle following the murder.

At approximately 6:30 pm an RCMP officer noticed the missing vehicle on Highway #3 near the Rae turn-off. The officer engaged his emergency lights and siren and attempted to stop the vehicle on the highway. The parolee did not stop as ordered and proceeded toward the capital city on highway #3.

A high speed car chase ensued for approximately 10 minutes before the parolee lost control and crashed the car into a ditch on the side of the roadway. He then ran into the dense bush.

The highway was closed to traffic while RCMP conducted a search for the missing man. He eventually surrendered to police without further incident at approximately 1:15 am on October 7th, 2004.

The Office of the Chief Coroner was notified of the death and attended to the scene. Forensic officers from RCMP "G" Division were on scene gathering evidence and obtaining photographs of the deceased and the crime scene.

The body of the deceased was removed and secured in a coroner's shipping container and placed in the coroner's vehicle. Continuity of the remains was maintained throughout the procedure. The body was transported to the airport and placed aboard the RCMP aircraft for transport to Edmonton for an autopsy.

At autopsy, a thin, white rope ligature was noted wrapped around the neck of the deceased several times and tied into a knot near the back of the neck. Petechiae were found in a number of locations including the eyes, eyelids and nose of the decedent.

Five lacerations were observed over the top and right side of the skull. At least three of the lacerations were associated with depressed fractures of the skull. The overall appearance of these injuries was consistent with having been caused by blows from a hammer.

Several small abrasions and bruises were also present over the face, arms and hands. An additional laceration was noted to be present on the back, forth finger of the left hand. There was also evidence of sexual assault.

The only evidence of any natural disease processes was a small benign tumour of the left ovary. This condition would not have caused or contributed toward death.

Post mortem toxicology was negative for the presence of any alcohol or intoxicating drugs in the blood sample provided.

In reviewing the investigation and documentation, the coroner ruled the cause of death as ligature strangulation with blunt cranial trauma thought to be a significant contributing factor in her death. The Coroner further classified the death as a homicide.

COMMENTS AND RECOMMENDATIONS:

A number of concerns and questions arose as a result of this investigation.

The investigation revealed that the deceased had been scheduled to meet with the parolee at his apartment at 10:00 am. She was scheduled to return to her office by 11:30 am. When she did not return, her colleagues attempted to locate her by phone. RCMP were eventually notified of her disappearance and attended to the parolee's apartment where they made the discovery at 3:00 pm approximately 5 hours after the start of the scheduled meeting.

The parolee had taken the deceased vehicle and was ultimately apprehended while in possession of the vehicle.

He was subsequently charged with first degree murder and eventually entered a plea of guilty to second degree murder and was sentenced to life in prison. He will be eligible for parole after several years.

The parolee was initially convicted in the death of another woman back in the 1980's. He was found guilty of second degree murder in that instance and sentenced to life in prison for the offence. The offence was later reduced to manslaughter and the parolee was released on day parole in 2000. The murder was sexually motivated and the parolee was thought to be likely to re-offend.

The deceased was first assigned as his parole officer in May of 2001. In July of that same year, the deceased recommended the parolee's day parole be revoked due to concerns regarding reported violence and aggressive sexual activity. In August of 2001, his day parole was revoked and he was returned to prison.

The parolee was again granted day parole in April of 2003 and granted full parole in June of that same year. In September of 2004, the parolee was notified that the deceased would once again be his parole officer and she was assigned that duty in October of 2004.

On December 22, 2004, following a review, Human Resources and Skills Development Canada, found that the CSC had contravened 5 provisions of the Canada Labour Code and issued 5 directives to the Yellowknife office of the Correctional Service of Canada. The CSC in turn appealed the directive.

There was also a National Joint Board of Investigation carried out by the Correctional Service of Canada and the National Parole Board. The investigation reviewed a number of issues surrounding this death and put in place some immediate changes to operations and made some additional recommendations/changes to how the Parole Board operates. Some of the changes include: requiring two officers for any visits during the first three months of a sex offender's parole, additional awareness training for staff, changes into information gathering and exchange and the protocols for developing and evaluating risk assessments.

Although the Office of The Chief Coroner supports these measures, the changes may not go far enough and some broader issues may not have been dealt with in their entirety.

Many of the issues involved in this death are too broad for even a Coroner's Inquest to review and evaluate. A concern over the public perception of an internal investigation is also something that needs to be taken under consideration since this parolee was known to stalk other women during his time on parole and that puts the general public at risk. Therefore, the Office of the Chief Coroner makes the following recommendation to the Solicitor General of Canada:

That the federal government order and carry out a full public inquiry into the circumstances surrounding the death. The inquiry should look at any and all facets of the incident, along with the circumstances in which the offender was dealt with during his entire involvement in the justice system. The inquiry should include but not be limited to: the protocols used for designating an individual as a dangerous offender, the practice of allowing female parole officers to oversee violent sexual offenders, and the value and risks associated with single officer home visits. In addition, the inquiry should review and assess the changes made to date by the Parole Board and issue any additional changes it deems appropriate.

It would seem prudent to deal with the issues involved in this case through a public process to both ensure a thorough review of the concerns present, and assure the public that everything that can be done to minimize another death of this nature, has been done.

CASE # 2

A 24 year old male was operating a plow-equipped truck on the frozen ice of Prosperous Lake when the vehicle was seen to break through the ice and sink. The deceased was unable to escape from the vehicle and his body was found by searchers a few days later.

Police and the coroner where notified and attended to the area. A large hole was noted in the ice. Photos were obtained and witness statements were collected. Representatives from the Worker's Compensation Board were also in attendance.

The investigation revealed that the deceased had been assisting in the plowing of a road on Prosperous Lake to gain access to the Bluefish hydro power plant.

A number of workers were on the site and began preparations to begin plowing the access road. The deceased and a supervisor began drilling "test" holes in the ice to measure the thickness. These holes were being drilled approximately every 1000 metres even though their normal operating procedure was to test every 500 metres. Approximately 12 holes were drilled along the 12 kilometre route. The thinnest ice was noted to be approximately 18 inches.

The temperature on that day was in the range of -30 to -35 C.

Four large units, equipped with snow plows were on site to plow the road. Two of the other workers began the procedure while the deceased and another worker were preparing to begin assisting the plowing procedure in their own vehicles.

The first 3 passes over the frozen lake were made without incident. The deceased was preparing to make his first pass which would be the 4th pass overall. This procedure was completed without incident.

As the decedent began to plow the road back in the opposite direction (his second pass, 6th overall), he noted a "soft" spot on the route and radioed to his supervisor that the area should be checked over. Shortly after, his vehicle was noted to break through the ice.

The deceased was seen to first attempt an escape out the drivers door and then made an attempt to escape the vehicle through the passenger door of the truck. The vehicle was not equipped with a roof escape hatch.

The vehicle was seen to disappear from view as it sank to the lake bottom. There was no sign of the decedent and no indication that he had escaped the vehicle or had surfaced. The broken ice chunks made it very difficult to access or properly visualize the open area.

Authorities were summoned to the scene and recovery efforts were employed. Arctic Divers were contacted and requested to attend the site to begin a search for the missing man. The divers noted that the depth at the site was approximately 400+ feet and well beyond their dive limitations. A cursory search of the area in and around the open water site was negative.

The family of the deceased brought in additional resources to search the lake bottom. An attempt was made to secure and raise the sunken plow. Although the vehicle was raised a significant distance from the lake bed, the hoist system failed before the truck could be brought to the surface and the plow retreated once more to the lake bottom.

A remote, camera equipped submarine was employed by the family and was able to open the cab door and view the inside of the truck cab. The decedent was not present in the cab. An extensive search of the lake bottom was made by the submarine and the body of the deceased was located and brought to the surface a few days after the initial incident.

The deceased was then transported to the Stanton Territorial Hospital morgue where a cursory external examination was held. There was no evidence of any obvious trauma to the deceased and all findings were consistent with drowning.

No autopsy was ordered but a vitreous fluid sample was obtained for routine toxicology examination. The tests revealed no alcohol or intoxicating drugs were present in the sample provided.

In reviewing the information and documentation, the coroner ruled the cause of death as drowning and classified the death as accidental.

COMMENTS AND RECOMMENDATIONS:

Further to additional investigations by The Worker's Compensation Board and Human Resources and Skills Development Canada (HRSDC) a number of recommendations and orders were drafted and provided to the company.

The Office of the Chief Coroner supports all of the recommendations put forward and encourages all parties involved to adopt and implement them as quickly as possible. Most notably the installation of escape hatches in all vehicles involved in ice road construction and the adopting and implementation of the industry accepted "Gold's Formula" for determining ice bearing capacity.

The display of gross vehicle weights on the side of vehicles should be implemented as well as the use of an ice profiler for determining ice thickness throughout the proposed route.

Due to the fact that many different operators in the NWT use a variety of methods and calculations for the determination of ice load capacities, the GNWT should consider drafting and adopting legislation concerning the construction of ice roads in the north, as suggested by the other investigating agencies.

CASE # 3

A 13 month old infant was found suspended in a "hammock like" sleeping device by a parent who had gone to check on him. The nurse was called and she instructed the caller to perform CPR and attend immediately to the nursing station.

Upon arrival, the infant was noted to be limp, unresponsive and starting to cool. A cursory examination was held and the infant was pronounced dead a short time later.

Police and the local coroner were contacted and attended to the health centre. Photographs of the infant were taken and witness statements were obtained. Authorities also attended to the residence and took additional photos and examined the sleeping device. There was no evidence of any foul play.

The investigation revealed that the infant had been put to sleep at approximately 1:00 am in a traditional Dene infant hammock. The device was secured by ropes which were anchored to the wall. A thin sheet was folded in a traditional manner to form a bed. A scarf was then fashioned around the sheet.

Upon examination at the residence, it appeared as though the sheet and scarf may have fallen through the ropes along with the infant and he had become suspended in this fashion.

The parent stated she had been with her other two children in the living room and had fallen asleep. When she awoke at approximately 4:20 am, she checked on the infant and found him suspended in the hammock. She brought the infant to the health centre where he was pronounced dead at 4:28 am.

An autopsy was ordered to be held in Edmonton. The body of the infant was prepared and transported to Alberta for the procedure.

At autopsy, there were several tiny pinpoint bleeding sites (i.e petechiae) scattered over the face which is consistent with the application of pressure to the neck. There were no natural disease processes and no other injuries present to cause of contribute toward the death.

Toxicology tests performed on blood and vitreous samples found no alcohol or intoxicating drugs in the samples provided.

In reviewing the information, investigation and documentation, the coroner determined that infant died as a result of hanging. The coroner has further classified the death as accidental.

COMMENTS AND RECOMMENDATIONS:

The coroner in this case has noted the common use of this traditional device among northern aboriginal families. It was suggested that the appropriate agency in each community help make families aware of the dangers present when using this device and remind them that constant monitoring of the infant should be undertaken when employing this traditional sleeping method.

Therefore, it is recommended to the Department of Health and Social Services, to provide material and guidance to local health centres and nursing stations of the "best practices" to recommend to families using traditional sleeping methods.

CASE # 4

A 32 year old man with a history of hydrocephalus, (i.e. fluid build up on the brain), spina bifida (i.e. defect in the spinal column) with paraplegia (i.e. paralysis) and depression was found dead in his bed by a home care worker and a family member.

An ambulance was called and attended to the apartment. The decedent was taken to Stanton Territorial Hospital where he was pronounced dead a short time later.

The coroner was contacted and subsequently called the RCMP and requested their assistance. Police attended to the hospital and the scene. RCMP obtained photographs and took witness statements. There were no signs of a struggle and no indications of any foul play.

The investigation revealed that the deceased had a medical history of hydrocephalus, spina bifida with paraplegia and depression. He had regular visits from home care workers who assisted him each morning.

The night previous to the discovery, the deceased was seen by a neighbour who visited with him and left his apartment at approximately 10:00 pm. The neighbour has a key and locked the apartment when he departed.

The next morning at approximately 8:45 am, a health care worker attended to the apartment. It was assumed that the decedent was asleep since that was the usual situation when the worker arrived. The home care worker proceeded to put coffee on and prepared to assist the deceased when he awoke.

A family member arrived a few minutes later to pick up some items from the residence. When they checked on the deceased to try and wake him up, they noted he was unresponsive and not breathing. CPR was undertaken and the ambulance was called. The deceased was transported to hospital but was pronounced dead at 10:10 am.

An autopsy was ordered to be held in Edmonton and the decedent was prepared for transportation to Alberta for the procedure.

At autopsy, there was evidence of hydrocephalus but no evidence of any new abnormalities of the brain. An excessive amount of fat was found in the muscle of the right side of the heart. This is seen in an uncommon disorder of the heart muscle called "right ventricular cardiomyopathy."

There were no other natural disease processes and no injuries present to cause or contribute toward the death.

Toxicology tests were negative for alcohol or illicit drugs. However, a high level (2.72 mg/l) of venlafaxine (i.e. an anti-depressant medication) was detected in the blood sample. The level was thought to be sufficiently high enough to cause death.

In reviewing the information, documentation and investigation, the coroner has determined that the cause of death was a result of venlafaxine toxicity. Depression was thought to be a contributing factor in his death. The coroner has classified the death as accidental.

COMMENTS AND RECOMMENDATIONS:

It is medically known that the condition of right ventricular cardiomyopathy can sometimes run in families.

The coroner has recommended that the Department of Health and Social Services contact any family members and suggest they be examined by a physician to be certain that they do not have this heart condition, especially if they have ever experienced unexplained seizures or fainting spells.

CASE # 5

A 40 year old man with a history of alcohol abuse fell over a banister and into a basement stairwell. He was transported to the local hospital where it was determined he had suffered broken ribs and was bleeding internally.

A medivac was ordered and the man was prepared for transfer to Edmonton. After arriving at the airport, his condition quickly worsened and he became unresponsive. Resuscitation efforts were employed and the man was returned to the H. H. Williams Hospital in Hay River where he was pronounced dead a short time later.

The local coroner and RCMP were notified and attended to the hospital. Police also attended to the scene of the incident. They took statements from witnesses and photographs of the stairwell and banister. Police noted no sign of a struggle and no evidence of foul play.

The investigation revealed that the deceased had been drinking earlier in the day and was resting on a couch in the residence. He was seen to get up off the couch and staggered toward the staircase. It was at this point that the deceased was known to fall over the banister and into the stairwell.

It was reported the deceased initially lost consciousness but became conscious a few minutes later. An ambulance was called and he was taken to the local hospital for evaluation and treatment. X-rays showed 3 or 4 broken ribs and other findings consistent with internal bleeding. He was placed on medication and given 2 units of blood.. The patient was conscious and coherent. C-spine x-rays showed no fractures and there was no indication of a closed head injury.

A medivac to Yellowknife was requested but according to witness statements, the Hay River facility was instructed to transport the decedent directly to Edmonton.

The medivac arrived at 6:35 pm. The patient was reported to be relatively stable and he was transported to the Hay River airport at 8:00 pm. He was loaded onto the aircraft and the ambulance left the airport.

At approximately 8:20, the decedent became unresponsive and the resuscitation efforts were commenced. The ambulance returned to the airport to transfer the deceased back to the hospital, arriving there at 9:00 pm. CPR was continued until the decedent was pronounced dead at 9:26 pm.

An autopsy was ordered to be held in Edmonton and the deceased was then prepared for transport to Alberta for the procedure.

Because it was clear through a review of the x-rays and additional medical information that the deceased had suffered extensive internal chest injuries, the autopsy consisted of only an internal head examination to determine if there were any closed head injury to the deceased.

The autopsy revealed, bruising present over the top of the scalp and the right side of the forehead. However, there were no injuries of the skull, brain or upper portion of the neck which would indicate any contribution to the cause of death. There were no natural disease processes involving the brain noted that could cause or contribute toward the death.

Medical records cleared documented the left side rib fractures and the internal bleeding (i.e. left hemothorax) in the left chest cavity.

Toxicology showed an intoxicating blood alcohol concentration of 2.12 g/l in an anti-mortem sample provided, as compared to the legal limit of .80 g/l for the purposes of operating a motor vehicle.

In reviewing the information and documentation, the Coroner, Doug Swallow has determined that the decedent died as a result of blunt chest trauma. Ethanol intoxication was thought to be a contributing factor in the death. The Coroner has classified the death as accidental.

COMMENTS AND RECOMMENDATIONS:

The Coroner in this case noted a number of concerns in the aftermath of the incident that caused the trauma to the deceased. A number of questions arose from the investigation, such as:

a) The length of time from the time of injury, to the transport to the medivac. ***(The Coroner noted that approximately 6 hours had elapsed from the time of the injury, to transport by ambulance to the medivac).***

b) Lack of protocol or documentation in determining medivac destination (i.e. Yellowknife or Edmonton). ***(The Coroner felt the documentation was unclear as to the protocol or process used for determining whether a patient of this nature should be sent to Yellowknife or to Edmonton).***

c) Lack of communication or protocol between medivac personnel and the physician in Hay River. ***(There were no documented discussions between the medflight personnel and the attending physician in regards to the patient's condition or prognosis prior to attending to the community).***

d) Criteria for determining number/kind of personnel for a critical medical transport. ***(It was unclear as to how or what protocol is used in determining whether more than one flight***

nurse should attend the medflight and whether or not additional personnel (i.e. physician) should also attend).

e) Insufficient blood supply for dealing with this type of trauma victim. ***(According to the Coroner's note's there was no mechanism or documented request for additional blood supply to be established for the medflight).***

f) Lack of ambulance protocol for medivac flight transfers. ***(The Coroner noted that the ambulance left the airport before the flight left and then had to called back when the decedent's condition worsened).***

In the interest of addressing these concerns, the Coroner makes the following recommendations:

To Medflight;

- Conduct a full review of Medivac procedures with a consideration for ensuring medical flight personnel confer with the attending physician/nurse to ensure first hand information on patient condition/status and requirements. ***(It could not be determined if the medflight personnel were briefed prior to the departure of the aircraft from it's home base).***

- The service consider a policy of dispatching two medflight personnel when patients are determined to by critically ill. ***(It was felt that it was unclear as to what procedure or protocol was used to determine if an additional nurse or physician should have considered for the medivac flight.)***

- Medflight consider carrying additional blood supply when dealing with cases where extensive blood loss or internal bleeding are apparent. ***(It was thought that additional blood from Stanton Hospital would be advantageous if required).***

To Hay River Ambulance service;

- Adopt a policy where the ambulance remains at the airport during medivac transfer until the aircraft is airborne. ***(This would minimize delays in responding back to the airport should the patient's condition deteriorate prior to departure).***

To Medical transportation:

- Disclose to all parties requesting medivacs, the protocol used in determining the home base for responding aircraft and the medivac destination. ***(The Corner felt it was unclear as to why an aircraft from Hay River was not used and as to how it is determined whether a medivac should go to Edmonton or Yellowknife. It was felt that dissemination of this information would help health care workers in other centres understand the protocol).***

CASE # 6

Three men were found drowned who were travelling to Fort Good Hope by power boat on the MacKenzie River. The boat was reported over due on the next morning and the RCMP were informed. A search was initiated using members of the local police, community volunteers, search and rescue personnel and several aircraft.

At approximately 1:00 pm, a lone survivor from the boat was located on a sand bar. The survivor reported that the boat had over turned and one of the men was missing soon after. Two other occupants held on to the overturned boat which eventually sank.

An extensive search was undertaken to and remains over the 3 individuals were located.

Police and the coroner were contacted and continued the investigation into the circumstances of the incident and subsequent deaths.

The investigation revealed that the four individuals had purchased liquor at the store in Norman Wells and had set out the trip to Fort Good Hope by boat. According to witnesses, all were showing signs of intoxication and none were wearing any floatation devices when seen. The survivor stated that they experienced bad weather, high winds and choppy water. At some point the boat overturned and they were exposed to the cold water.

COMMENTS AND RECOMMENDATIONS:

The coroner noted that drowning in the NWT often occur when individuals who are boating neglect to wear any type of floatation device while on the water. It was felt that it may be prudent for the government to consider making the wearing of such apparel mandatory in the NWT.

CASE # 7

A 23 year old man was pulled from the Bekere Lake approximately 35 – 40 minutes after falling into the water from a canoe. Personnel on site began resuscitation efforts and a helicopter was used to transport him to the Inuvik Regional Hospital where he was pronounced dead shortly after his arrival.

RCMP and Coroner were notified and attended to investigation the death. Representatives from the Worker's Compensation Board were also required to attend. Police took photographs and collected statements from a variety of witnesses. They reported no evidence of any foul play.

The investigation revealed that the deceased had finished working his day shift at the camp and had decided to do some fishing at approximately 2:00 pm. At approximately 2:45pm, one of the camp workers heard cries for help coming from the lake.

He and another worker climbed on some ATV's and headed to the shoreline. They could see the overturned canoe and the decedent thrashing in the water. He did not appear to be wearing a floatation device. A few moments later he slipped below the surface.

They made some attempts to search but were initially unsuccessful. With the help of a boat, the body was later recovered. The workers were also able to snag his clothing and hoist him to the surface.

One of the helicopters supplying the camp arrived shortly thereafter and was seconded to transport the deceased to the hospital. CPR was continued during the transport. The helicopter arrived in Inuvik at about 5:00 p.m. and he was pronounced dead at approximately 5:20 pm.

An Autopsy was ordered to be held in Edmonton and the remains of the deceased were prepared and transported to Alberta for the procedure.

At Autopsy, there are no injuries or natural disease process present to cause or contribute toward the death. Toxicology was positive for a small presence of alcohol in the samples provided. An alcohol level 0.17g/l was noted in the vitreous sample while the urine sample yield less than 0.14 g/l and the blood sample was also less that 0.14g/l as compared to the legal limit of 0.80 for the purpose of operating a motor vehicle.

In reviewing the information and documentation, the coroner has determined that he died as a result of Drowning. The death was classified as an Accidental.

COMMENTS AND RECOMMENDATIONS:

The investigations by the WCB resulted in one recommendation to the company suggesting that they implement and enforce a policy requiring mandatory wearing of life vest by person on the water at all times.

The Office of the Chief Coroner echo's the recommendation and adds that the company should consider a training programs for employees who might be engaged in operating watercraft or all terrain vehicles to ensure both compliance with the safe operation of such vehicle and to demonstrate competency in operating them.

APPENDIX "B"

SUMMARY OF CORONERS' INQUESTS CONTAINING RECOMMENDATIONS (CONCLUDED IN 2007)

INQUEST

Kenneth Moore McFee DOD: July 24th, 2006

An Inquest into the death of Kenneth Moore McFee, who died on July, 24th 2006 was held in Courtroom #1 of the Yellowknife Court House.

Mr. McFee was a resident of the Northern United Place apartment complex in Yellowknife. On the evening of July 23rd, 2006, Mr. McFee entered elevator # 2 on the fifth floor. One other male occupant was on the elevator when Mr. McFee entered. The elevator door closed and the elevator proceeded down toward the lobby.

A few moments later, the city of Yellowknife was hit with a power blackout which caused the elevator in which Mr. McFee and the other occupant were riding, to become stuck between the third and forth floors of the building.

The elevator was not equipped with a telephone or other communication devise. The emergency alarm button was in place and was used by the trapped individuals to notify building security.

The elevators in the building are equipped with an emergency power source which will allow each of the two elevators to be powered during a blackout, but only one elevator at a time can be selected to engage the power source.

A keyed switch designed for this purpose is located on the wall between the elevators on the first floor. The unit was in the off or neutral position at the time of the power failure.

Security personnel made contact with the trapped individuals and informed them that efforts were being made to secure their release.

A security officer was informed that there was a key to the power transfer switch in the main office of the building and was instructed to retrieve the key and affect a power transfer to elevator number 2 to allow the elevator to continue it's intended journey down to the lobby.

An attempt was eventually made to transfer the power but the keyed switch would not turn. A locksmith later reported that the switch was in proper working order but the key was faulty and would only operate if fully inserted and then pulled back about 1/8th of an inch

During the time the key in question was being sought after and applied, *(about 15-20 minutes)* the occupants of the elevator were able to push open the elevator car door and gain access to the third floor landing door. By overriding the manual door latch, they were able to open the landing door as well.

The other occupant of the elevator slipped through the narrow opening and set down on the 3rd floor landing. As Mr. McFee attempted to exit the elevator car, he slipped, struck the third floor landing and fell forward (under the elevator car) into the open elevator shaft. He suffered significant internal injuries as a result of the fall.

Ambulance personnel arrived on the scene shortly thereafter along with building officers, the RCMP and a representative from the Elevator maintenance company. The first floor landing door was opened and Mr. McFee was removed from the shaft and transported to Stanton Territorial Hospital where he was pronounced dead in the early morning hours of July 24th, 2006.

The inquest focussed on areas involving elevator inspections, servicing, testing and current legislation.

The inquest heard from 12 witnesses and 41 exhibits were entered as evidence. The jury deliberated for approximately 4.5 hours before returning their unanimous decision.

They determined that Mr. McFee died on July 24th, at Stanton Territorial Hospital. The cause of death was determined to be, multiple blunt trauma and the death was ruled accidental.

The jury made a total of 18 recommendations regarding the death of Mr. McFee. They are listed below as they appear on the original verdict form. (The words in *italics* following each recommendation are the opinion of the Chief Coroner as to the jury's rationale and are provided to assist the reader in understanding the recommendation. They are not to be considered as an actual component of the inquest.)

1. **To the GNWT: Amend current Legislation to mandate that all passenger elevators in the Northwest Territories be modified to meet current code standards in regards to door restrictors on the car doors, and be implemented no later than one year after legislation is passed.** *(The jury heard testimony that the elevator in question was only required to meet the elevator codes in place in 1975 and that the unit was not currently required to meet the current code which calls for elevators to have door restrictors in place in ensure that the car door cannot be opened from inside the elevator car. The jury felt this legislation should be changed in the interest of safety).*

2. **To the GNWT: Amend current legislation to ensure that any keys required for the operation of an elevator or any emergency equipment are created by a certified locksmith and tested, and that all subsequent keys are to be created and tested in the same manner.** *(The jury heard testimony that the power transfer key likely malfunctioned because it was probably created on a duplicating machine and may have been a copy of a copy which can result in a imperfect duplication. It was felt that the use of a locksmith would minimize any possibility of a copying error. It was also determined that no prior testing of any of the keys available had been documented. The jury felt that legislation in this area may be beneficial in ensuring that emergency keys operate as expected.).*

3. **To the GNWT: Amend current legislation to mandate all passenger elevators in the Northwest Territories to have a telephone or intercom system installed and monitored 24 hours a day.** *(The jury heard testimony*

that the 1975 legislation that the current elevator was allowed to be operated under does not require this function. It was felt that if such communication was possible, better direction and communication with the trapped individuals may avert a similar situation).

4. **The jury recommends that as a temporary measure** *(until legislation is amended)* **a universal symbol be placed on the top and bottom of the interior face of the hall door as a caution to passengers, not to attempt to open the hall door.** *(The jury felt that such notices might help prevent someone from continuing to attempt to exit a stuck elevator. It was not clear to whom this recommendation was to be made or whether it was suggested as a voluntary gesture or to be legislated. It therefore could be considered by the GNWT, the building owners/managers or the elevator maintenance company.).*

5. **To the NWT Fire Marshal and electrical Inspector: perform or delegate an audit and inspection of all elevators in the Northwest Territories, operating with remote power switches, to ensure that they are operational and that a record be maintained. Inspections to be done twice a year.** *(The jury heard conflicting testimony as to which organization or agency is responsible for checking and maintaining the elevator power transfer switch).*

6. **To the Northern United Place building manager: We** *(the jury)* **recommend that it be the building manager's responsibility, on a monthly basis, to check that all keys in distribution, remain functional,** *(The jury noted that there is no current policy or practice regarding the testing of emergency keys).*

7. **To the Northern United Place building manager: All keys required for the operation of emergency equipment, be made available to appropriate staff in buildings where elevators are installed and that they be available in a convenient location to all emergency responders. The keys should be clearly labeled.** *(The jury heard that security personnel were not immediately aware of the location or operation of the power transfer switch and that the local fire department did not have any independent access to the key.).*

8. **To the Northern United Place building manager: The jury recommends that an advisory card be installed outside each elevator, indicating emergency numbers to call if there are passengers stuck in an elevator and a warning to potential rescuers not to attempt to open the doors to release the passengers inside..** *(The jury noted there was no such notice or warning currently displayed.).*

9. **To the NWT Community Services Corporation: The organization should complete as soon as possible, any and all safety modifications to the elevators in Northern United Place that are recommended by their contracted elevator maintenance provider.** *(The jury heard testimony regarding elevator upgrades and safety warning notices that were made*

available to the building owners but were not slated for immediate implementation).

10. **To all building operation managers in the NWT: All building operation managers provide operational and emergency training, both general and specific, to all security personnel to the building in their charge.** *(The jury heard testimony that no general or specific emergency training was provided to security staff at Northern United Place. The jury felt that such training and information be provided on a universal scale in the NWT).*

11. **To the GNWT: Adopt a policy to send out by mail and by electronic mail, "Safety Bulletins" to all elevator operator/license holders as well as posting it on the government website.** *(The jury heard evidence that the general practice is to only post the bulletins on the web site. It was felt that a more pro-active approach to disseminating the information was appropriate).*

12. **To the GNWT: The government should conduct a review of public education on elevator safety by the authority having jurisdiction.** *(The jury was made aware of a previous public education initiative and felt the concept should be explored further. This recommendation also mimics one made by the Chief Elevator Inspection in his report of this incident.).*

13. **To NWT Security Providers: All security providers provide to all of their security personnel, operational and emergency training, both general and specific to the building in their charge.** *(This recommendation basically mirrors recommendation number 10 above, but is directed to the security companies themselves.)*

14. **To Thyssen-Krupp Elevator Limited: The maintenance company , in conjunction with The Fire Marshal, the Chief Elevator Inspector and the local Fire Departments, facilitate information sessions specifically designed for building owners to inform and ensure awareness of; a) best practices in the industry for elevator safety and maintenance. b) owners responsibilities and record-keeping (including checklists) required, and to properly discharge these responsibilities.** *(The jury felt that some of the requirements for record keeping and testing were not properly communicated between several organizations and it was unclear as to who might be responsible for certain tasks. It was felt that a meeting/training session involving all parties might be beneficial).*

15. **To the NWT Fire Marshal: Establish a regulation or order within the Fire Marshal's office, an on-going auditing program to verify compliance with those matters which are an owner or owner's agent responsibilities under the compliance parts of C.S.A. B-44 and the national Fire code as well as the Fire Prevention Act and Regulations.** *(The jury was made aware that some requirement, inspections and verifications mandated under legislation were not being applied universally. It was felt a*

more accurate and formal auditing program would improve this component of the process).

16. **To the Northern United Place building manager: The jury recommends, as a temporary measure that building personnel have written policies to their staff directing that staff make every effort to locate the elevator car and prevent an attempted exit of trapped parties until restrictors are installed.** *(The jury felt this practice might be helpful until legislation regarding door restrictors is passed and implemented).*

17. **To the GNWT: The jury recommends the education program of the Regulatory Authority with respect to elevator safety be better financed and better supported by building owners, government, elevator maintenance contractors and all other interested parties.** *The jury appears to be calling for more resources and partnerships in regards to awareness training similar to what is mentioned in recommendation number 12 above).*

18. **To Thyssen-Krupp Elevator Limited: To work with building operation managers to clearly communicate what role each plays in maintaining the elevators. This should be clearly stated in a written contract and adhered to.** *(The jury heard conflicting testimony as to who might be in charge of certain components of the inspection process. It was felt that a meeting between the maintenance contractor and the building manager would clear up any confusion and insure that all checks and inspections are being properly and diligently performed).*

CORONERS ACT

Duty to Notify ***8. (1) Every person shall immediately notify a coroner or a police officer of any death of which he or she has knowledge that occurs in the Territories, or as a result of events that occur in the Territories, where the death***

(a) occurs as a result of apparent violence, other than disease, sickness or old age;

(b) occurs as a result of apparent negligence, misconduct or malpractice;

(c) occurs suddenly and unexpectedly when the deceased was in apparent good health;

(d) occurs within 10 days after a medical procedure or while the deceased is under or recovering from anesthesia;

(e) occurs as a result of

(i) a disease or sickness incurred or contracted by the deceased,

(ii) an injury sustained by the deceased, or

(iii) an exposure of the deceased to a toxic substance, as result or in the course of any employment or occupation of the deceased;

(f) is a stillbirth that occurs without the presence of a medical practitioner;

(g) occurs while the deceased is detained or in custody involuntarily pursuant to law in a jail, lock-up, correctional facility, medical facility or other institution; or

(h) occurs while the deceased is detained by or in the custody of a police officer.

Exception ***(2) Notwithstanding subsection (1), a person need not notify a coroner or a police officer of a reportable death where the person knows that a coroner or police officer is already aware of the death***

Duty of police officer

(3) A police officer who has knowledge of a reportable death shall immediately notify a coroner of the death.

Special reporting arrangements

(4) The Chief Coroner may make special arrangements with medical facilities, correctional facilities and the Royal Canadian Mounted Police for the efficient notification of reportable deaths by persons in those facilities or that organization.